South Carolina Health Insurance Pool (SCHIP)
Assessment Base Reporting Form

This form must be completed and submitted, postmarked by MARCH 1, 2006, by any insurer licensed to write accident and health insurance in South Carolina, even if all amounts are zero.	**Submit by MARCH 1, 2006, to:** *C. Michael Jordan, AF-210* *Chairman, SCHIP* *Blue Cross Blue Shield of SC* *I-20 at Alpine Road* *Columbia, SC 29219* *Tel (803) 264-4170 Fax (803) 264-5162* *E-mail mike.jordan@bcbssc.com*	Please submit to the address shown. Do NOT send to the South Carolina Department of Insurance and no overnight deliveries please.

1. TOTAL 2005 DIRECT A&H PREMIUMS WRITTEN IN S.C. $_____
(Should agree with total direct A&H premiums written in South Carolina as shown on the State Page or Schedule T of the Annual Statement.)

2. PREMIUMS EXCLUDED FROM SCHIP ASSESSMENT:
(Deduct only to the extent included in line 1. above.)

(a) Coverage only for accident, or disability income insurance, or any combination thereof $_____
(b) Credit-only A&H insurance $_____
(c) Coverage for on-site medical clinics $_____

If offered separately:
(d) Limited scope dental or vision benefits $_____
(e) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof $_____

If offered as independent, noncoordinated benefits:
(f) Coverage only for a specified disease or illness $_____
(g) Hospital indemnity or other fixed indemnity insurance $_____
(h) If offered as a separate insurance policy, coverage supplement to coverage provided under Chpt 55, Title 10 of the U.S. Code (i.e., Tricare supp) $_____
(i) Federal Employees Health Benefit Program $_____
(j) Medicare Advantage (Note: Med. supp. premiums are not excluded.) $_____

TOTAL EXCLUSIONS (a+b+c+d+e+f+g+h+i+j) $_____

3. 2005 SCHIP ASSESSMENT BASE (1. minus 2.) $_____

Does your company write individual major medical insurance in South Carolina?

_____ Yes _____ No 2005 S.C. Indiv. Maj. Med. Premium $_____

I certify that this information is correct and that these figures accurately reflect premiums written in South Carolina during 2005. I also understand that the amount on line 3. above will be used to determine my company's share of assessments made for losses of the South Carolina Health Insurance Pool.

Company Name _____ NAIC Code No _____

Signature of Authorized Officer _____ Date _____

Typed/Printed Name of Officer _____

Please provide the name, address, telephone number, and e-mail address for:

Contact person for this form: _____

Person to whom assessment notices should be sent: _____